LOCAL OPERATING PROCEDURE

CLINICAL POLICIES, PROCEDURES & GUIDELINES

Approved by Quality & Patient Care Committee
20 April 2017

THIRD AND FOURTH DEGREE PERINEAL TEARS – REPAIR AND MANAGEMENT

This LOP is developed to guide clinical practice at the Royal Hospital for Women. Individual patient circumstances may mean that practice diverges from this LOP.

1. AIM

- Correct identification and classification of 3rd and 4th degree tears
- Reduce the adverse impact of 3rd and 4th degree tears on a woman's health by:
  - Performing repair under optimal circumstances without delay
  - Using correct surgical technique to obtain optimal anatomical repair
  - Reduce the risk of developing a haematoma/infection/wound breakdown
  - Preserving long term sphincter function

2. PATIENT

- Woman sustaining 3rd or 4th degree perineal tear as defined below:

First degree:	Injury to perineal skin, includes the fourchette, the hymen, labia and vaginal mucosa
Second degree:	Injury to perineum involving perineal muscles but not involving the anal sphincter
Third degree:	Injury to perineum involving the anal sphincter complex: • 3a: Less than 50% of external anal sphincter (EAS) thickness torn • 3b: More than 50% of EAS thickness torn • 3c: Both EAS and internal anal sphincter (IAS) torn
Fourth degree:	Injury to perineum involving the anal sphincter complex (EAS and IAS) and anal epithelium
Rectal buttonhole:	Injury to anorectal mucosa but not anal sphincter. These are not fourth degree tears but can lead to rectovaginal fistulae if not repaired.

3. STAFF

- Registered Midwives
- Medical staff suitably competent to perform complex perineal repair (or under supervision of Senior Medical Officer)
- Physiotherapist

4. EQUIPMENT

- Surgical equipment

5. CLINICAL PRACTICE

- Perform adequate perineal examination (after verbal consent) for all women sustaining perineal trauma. This will usually require a rectal examination if there is significant perineal trauma or vaginal lacerations
- Call medical officer to inspect the perineum if 3rd or 4th degree tear is suspected
- Arrange transfer to theatre for repair, if a 3b, 3c or 4th degree tear is confirmed
- Consider transfer to theatre for repair if a 3a tear is confirmed for adequate analgesia, lighting and asepsis

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- Obtain written consent for repair in theatre or verbal consent for repair in Delivery Suite and document
- Suture as soon as possible after birth to reduce the risk of bleeding and infection
- Discuss choice of anaesthesia with the anaesthetic team and the woman. Regional anaesthesia is usual practice
- Repair the anorectal mucosa using either:
  - 3--0 polyglactin (Vicryl®) with either continuous or interrupted technique, as recommended by the Royal College of Obstetricians and Gynaecologists
  - interrupted 3--0 polydiaxanone (PDS), as recommended locally by colorectal surgeons
- Repair the external anal sphincter. Either an overlapping or end--to--end (approximation) method can be used, with equivalent outcome
- Repair the EAS muscle with either of the following as they give equivalent outcomes:
  - monofilament sutures such as polydiaxanone (PDS)
  - braided sutures such as polyglactin (Vicryl®)
- Identify a possible IAS. It is advisable to repair this separately with interrupted sutures
- Repair the IAS muscle with fine suture material such as 3--0 PDS or 2--0 polyglactin as this may cause less irritation and discomfort
- Bury the surgical knots beneath the superficial perineal muscles to prevent knot migration to the skin
- Repair the remainder of the perineal tear as per the usual method for second degree tears and perform rectal examination (PR) at the completion of the repair
- Recommend the use of broad--spectrum antibiotics following obstetric anal sphincter repair to reduce the incidence of postoperative infections and wound dehiscence. Suggested regimen (if woman not allergic):
  - Initial 24 hours, intravenous (IV) Metronidazole 500mg 8 hourly and IV Cephalothin 500g 6 hourly
  - Followed by 5 days oral Augmentin Duo Tablets (Amoxicillin/Clavulanic Acid 500mg/125mg) 12 hourly
- Recommend the use of postoperative laxatives. Suggested regimen:
  - Stool softener: Lactulose® 20mls daily or
  - Bulking agent: Fybogel® 1 sachet bd for 10 days
- Refer woman to physiotherapy department. Referral to be made to physiotherapy via EMR by medical staff at time of repair. Recommend pelvic floor exercises for 6–12 weeks.
- Arrange medical review within 48 hours after birth to discuss diagnosis and implications of tear and importance of follow--up
- Arrange review for all women who have had obstetric anal sphincter injury (OASI) and repair at 4 weeks and 4 months postpartum in the Obstetric Anal Sphincter Injury Service (OASIS) clinic

6. DOCUMENTATION

- Integrated Clinical Notes
- Consent form
- Operation Report
- Third Degree Tear form
- eMaternity
- Partogram
- eMeds

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7. EDUCATIONAL NOTES

- Women should be fully informed about the nature of their injury and the benefits to them of follow--up. This should include written information where possible
- Women should be advised that the prognosis following EAS repair is good, with 60–80% asymptomatic at 12 months. Most women who remain symptomatic describe incontinence of flatus or faecal urgency
- All women who sustained an OASI in a previous pregnancy should be counselled about the risk of developing anal incontinence or worsening symptoms with subsequent vaginal delivery. There is no evidence to support the role of prophylactic episiotomy in subsequent vaginal deliveries. Women who are symptomatic or have abnormal endoanal ultrasonography and/or manometry should have the option of elective caesarean birth
- According to RCOG Green top guideline No 29, June 2015 "*if the tear only involves mucosa with an intact anal sphincter complex (buttonhole tear) this has to be documented as a separate entity. If not recognised and repaired this type of tear may cause anovaginal fistula*"
- According to RCOG Green top guideline No 29, June 2015 polyglactin is preferable to PDS for repair of anorectal mucosa as it may cause less irritation and discomfort (level D evidence)

8. RELATED POLICIES / PROCEDURES / CLINICAL PRACTICE LOP

- Perineal/Genital Tract Repair
- Accountable items in birthing environment (outside Operating Theatre)
- Third or Fourth Degree Tear – care of a postnatal woman

9. NATIONAL STANDARD

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12. REFERENCES

1 The management of third-- and fourth-degree perineal tears. RCOG green-top guideline no. 29. June 2015

REVISION & APPROVAL HISTORY
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